U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 18Dec2001

In the matter of
Scott A. Woods,
Claimant

Case No. 2001-BLA-0518

v.

Clinchfield Coal Company,
Employer

and

Director, Office of Workers' Compensation Programs,
Party-in-Interest.

APPEARANCES:

On behalf of Claimant:
Joseph E. Wolfe, Esquire
Wolfe & Farmer
P.O. Box 625
Norton, VA 24273

On behalf of Employer:
Timothy W. Gresham, Esquire
Penn, Stuart & Eskridge
P.O. Box 2288
Abingdon, VA 24212

BEFORE:
Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS[1]

Jurisdiction and Claim History

This case comes on a request for hearing filed by the Claimant, Scott A. Woods, on March 28, 2000 pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§901 *et seq.* (the Act.). Claimant originally filed a claim for Black Lung benefits on October 26, 1983 (DX 1). An initial finding of entitlement was made by the District Director on January 29, 1985 and reiterated on May 30, 1985 (DX 22-111A).

On June 4, 1985, the Employer, Clinchfield Coal Company, requested reconsideration of the

[1] 20 CFR § 725.477, 5 CFR § 554-7 (Administrative Procedure Act), and also 20 CFR § 725.479 Finality of decisions and orders.

finding of entitlement, or in the alternative, a formal hearing before the Office of Administrative Law Judges (DX 22-111A). Following a formal hearing held on March 4, 1988, Administrative Law Judge T. Eugene Burts issued a Decision and Order, dated July 1, 1988, denying benefits (DX 55).[2] The Claimant filed a timely appeal with the Benefits Review Board ("BRB"), which subsequently issued a Decision and Order, dated September 27, 1990 (BRB No. 88-2677 BLA), affirming Claimant's denial of benefits (DX 61).

On July 19, 1991, Claimant filed a Motion for Modification with the District Director (DX 65). Subsequently, Claimant requested a formal hearing (DX 71), which was held before Honorable Joan Huddy Rosenzweig on May 5, 1993 in Abingdon, Virginia (DX 22-110). By Decision and Order, dated March 23, 1994, Judge Rosenzweig denied Claimant's application for benefits (Id.). In denying Claimant's benefits, Judge Rosenzweig, despite finding that Claimant's recently submitted medical evidence established a change in conditions, concluded that Claimant failed to establish total disability due to pneumoconiosis pursuant to 20 C.F.R. § 718.204(c) and (b).

On appeal, the Board affirmed Judge Rosenzweig's finding that a change in condition was established, but remanded the case for her to weigh all of the relevant evidence regarding the exertional requirements of Claimant's coal mine employment and to compare the opinions of Drs. Fino and Branscomb with those requirements. ***Woods v. Clinchfield Coal Co.,*** BRB No. 94-2311 BLA (Feb. 16, 1995)(unpub.) (DX 22-121). Upon remand, Judge Rosenzweig, after further consideration and analysis, found that, with the exception of lifting 160 pounds[3] one (1) time per day, Claimant's job was sedentary, sitting during his eight-hour shift (DX 22-119).[4] Judge Rosenzweig then concluded that Claimant again failed to establish total disability pursuant to 20 C.F.R. § 718.204(c) and was not entitled to benefits under the Act (Id.).

For the third time, the Board was asked to reconsider an Administrative Law Judge's decision to deny benefits to Claimant (DX 22-121). In affirming Judge Rosenzweig's Decision and Order, dated August 12, 1996, the Board held that the administrative law judge reasonably concluded that Claimant's job as a shuttle car operator entailed predominantly light, to sedentary, work with only very limited somewhat heavy exertion (Id.). Moreover, the Board acknowledged that the administrative law judge acted within her discretion in finding the opinions of Drs. Sargent and Fino to be "persuasive," specifically that the opinions were rendered by "pulmonary specialists" who wrote "extremely thorough and well reasoned [reports] consist[ing] of in-depth analyses of the available evidence" (DX 22-121, DX 22-119). As such, the Board affirmed the denial of benefits due to Claimant's failure to establish

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[2] Judge Burts found that the evidence established the existence of pneumoconiosis arising out of Claimant's coal mine employment pursuant to 20 C.F.R. §§ 718.202(a)(4) and 718.203(b), but concluded that the evidence did not establish total disability pursuant to 20 C.F.R. § 718.204(c).

[3] Claimant testified in his March 3, 1985 deposition that the 160 pounds referred to barrels of oil, which he lifted to waist-level height and pushed onto the shuttle car (EX 6, DX 22-119).

[4] Judge Rosenzweig found that Claimant's duties in his shuttle car operator job are most accurately described in the Description of Coal Mine Work and Other Employment form (DX 6).

total respiratory disability pursuant to 20 C.F.R. § 718.204(c).

Claimant filed his most recent duplicate claim[5] on March 28, 2000, naming Clinchfield Coal Company as the responsible operator (DX 24). On July 5, 2001, I issued an Order regarding the black lung regulations amended on December 20, 2000. The effective date is January 19, 2001. At that time, the regulations were the subject of a preliminary injunction before the United States District Court, District of Columbia, ***National Mining Ass'n v. Elaine Chao, Secretary of Labor***, Case No. 1:00CV03086. The parties each submitted briefs on the issue; however, the matter is now moot.

A hearing was held July 24, 2001 in Abingdon, Virginia. The Claimant was represented by Joseph E. Wolfe, Esquire, of Wolfe, Farmer, Williams & Rutherford, located in Norton, Virginia. Clinchfield Coal Company (hereinafter "Employer") was represented by Timothy W. Gresham, Esquire, of Penn, Stuart & Eskridge, located in Abingdon, Virginia. At the hearing, twenty-four (24) Director's Exhibits were entered into evidence, as were twenty-eight (28) Employer exhibits.[6] Lastly, post-hearing briefs were submitted by the Claimant and Employer and are admitted into evidence.

The Claimant was born April 13, 1943 (EX 6), making him fifty-eight (58) years of age at the time of the hearing. On November 16, 1963, he married the former Ruth Phillips (DX 1). They are currently still married and living together (Id.). The couple has three (3) children, Michael, Beverly and Kimberly (EX 6, DX 22-107A).

Claimant testified that he began working for Clinchfield Coal Co. in 1971 at their Camp Branch #1 site (Id.). Claimant's last usual coal mine job was as a shuttle car operator for Clinchfield; however, that ended on March 26, 1982 when he broke his leg (Id.). Claimant testified that he received workers' compensation while his leg healed, but during that time period, the mines shut down (Id.). Claimant further testified that he would have returned to coal mine work in August of 1982 if it wasn't for the mines being shut down (Id.). Instead, Claimant stated that he received unemployment compensation for twenty-six (26) weeks, beginning in August of 1982 (Id.). Claimant testified that he did not return to the mines in 1983 based upon the advice of Dr. Robinette, who told him that his work in the mines was over because his lungs were too bad (EX 27, DX 22-107A).[7]

Claimant testified that his breathing was getting worse before leaving the mines (DX 22-107A).[8] During his physical examination with Dr. Rasmussen, dated June 28, 2000, Claimant stated

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[5] The claimant's prior claims are administratively final.

[6] References to "DX" are exhibits of the Director, whereas the Employer's are marked "EX."

[7] Claimant stated in his medical examination with Dr. Hippensteel, dated March 12, 2001, that he was told by Dr. Robinette that he should not go back to work (in the mines) because of (his) breathing (EX 27).

[8] In regards to his breathing troubles, Claimant testified that he would have to rest during and after taking supplies down. Furthermore, Claimant stated that, prior to experiencing breathing problems, it would only take him one hour to load supplies, as opposed to the two hours it took him after he begun to experience breathing problems (DX 22-107A).

that he began to experience progressive shortness of breath with exertion some twenty (20) years ago (DX 6). During his May 5, 1993 hearing before Judge Rosenzweig, Claimant complained of having episodes of increased shortness of breath (EX 1, DX 22-107A). Furthermore, Claimant added that he becomes quite dyspneic after climbing a single flight of stairs (Id.). In addition to his breathing problems, Claimant also has pains in his chest, an arthritic hip, had a bout with pneumonia in December 1999 and suffers from chronic bronchitis (DX 6, DX 22-109). Claimant also acknowledged that he had suffered a stroke, which has affected his memory (DX 22-109).

Despite being affected by these illnesses over the years, Claimant has a significant smoking history. Claimant began smoking one (1) pack of cigarettes a day at the age of sixteen (16) (DX 6, DX 22-109). Claimant then continued to smoke approximately two (2) packs of cigarettes per day until quitting on June 23, 2000 (DX 6).

Material Change in Condition

Any time within one (1) year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.310. However, after the expiration of one (1) year, the submission of additional material or another claim is considered a duplicate claim which will be denied on the basis of the prior denial unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. § 725.309 as interpreted by the Benefits Review Board and Federal Courts of Appeal. Under this regulatory provision and according to the Court of Appeals for the Sixth Circuit in ***Sharondale Corporation v. Ross***, 42 F.3d 993, 997-98 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the ***Sharondale*** approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in ***Peabody Coal Company v. Spese,*** 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

On August 12, 1996, Judge Rosenzweig denied Mr. Wood's claim because Claimant failed to establish total disability pursuant to 20 C.F.R. § 718.204(c) (DX 22-119). The Board affirmed the denial of benefits in a Decision and Order dated July 23, 1997 (DX 22-121). As a result, to demonstrate that a material change in condition has occurred since the denial of his prior claim, Claimant must prove, based on evidence developed since August 1996, that he has total respiratory disability pursuant to 20 C.F.R. § 718.204(c).

As a I find that Claimant has established that he has a total respiratory disability to which he cannot perform his last coal mine job, I find that Claimant has established that a material change in his condition has occurred since his last application of benefits had been denied.

Burden of Proof

"Burden of proof," as used in the this setting and under the Administrative Procedure Act[9] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)[10]. The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[11]

The Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. ***Gee v. W.G. Moore and Sons***, 9 B.L.R. 1-4 (1986)(*en banc)*; ***Baumgartner v. Director, OWCP***, 9 B.L.R. 1-65 (1986)(*en banc)*.

A Claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[12]

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[9]33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[10] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[11] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[12] ***Id***, *also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

Therefore, the claimant cannot rely on the Director to gather evidence.[13] A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985). Evidence which is in equipoise is insufficient to sustain claimant's burden in this regard. ***Director, OWCP v. Greenwhich Colleries, et al.,*** 114 S. Ct. 2251 (1994), *aff'd sub nom.* ***Greenwhich Collieries v. Director, OWCP,*** 990 F.2d 730 (3rd Cir. 1993). Failure to establish any one of these elements will result in a denial of benefits. ***Hall v. Director, OWCP,*** 2 B.L.R. 1-998 (1980).

Issues Presented

The following issues are listed as contested by the Employer:[14] (1) whether the medical evidence establishes that the Miner suffered from pneumoconiosis pursuant to 20 C.F.R. § 718.202(a); (2) whether Claimant's pneumoconiosis arose, at least in part, out of coal mine employment; (3) whether the Claimant is totally disabled; (4) whether Claimant's disability is caused by pneumoconiosis pursuant to §§718.204; and (5) whether a material change in condition has occurred pursuant to 20 C.F.R. § 725.309 (c), (d).

The Employer did not contest that Ruth Phillips Woods is a dependent of the Claimant.

Stipulations

The parties agree that Claimant timely filed his claim for benefits, that Claimant falls within the statutory definition of "miner" pursuant to 20 C.F.R. § 725.202, that he worked as a miner after December 31, 1969 and Claimant worked for nineteen (19) years in coal mine employment (Tr. 9). The parties further agree that Clinchfield Coal Company is the responsible operator and has secured payment of benefits (Tr. 7). Additionally, the parties stipulated that in the State of Virginia, the receipt of a workers' compensation award for black lung does not necessarily mean disability; instead, it only means an existence of a certain level of pneumoconiosis. The parties further stipulated that Claimant in 1974 received a staged award for the level of pneumoconiosis. Lastly, the parties agreed that Claimant's daughter, Beverly, was over eighteen (18) and not in school in 1990 when Claimant filed his first modification.

Medical Evidence

The following is a summary of the evidence of record:

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[13] ***Id***.

[14] See the CM-1025 (DX 23).

			X-Ray Interpretations	
	Exhibit No.	***Date of X-Ray***	***Physician and Qualifications[15]***	***Diagnosis/History Noted Comments***
1.	DX 22.74.2	6-7-74	Navani, BR, BCR	Positive; 1/0, p; scattered densities indicating presence of CWP.
2.	DX 22.26	2-25-76	Navani, BR, BCR	Positive; 0/1, p; no significant of CWP are seen.
3.	DX 22.25	3-15-76	Wheeler, BR, BCR	Unreadable.
4.	DX 22.25	3-15-76	Morgan, BR, BCR	Unreadable.
5.	DX 22.25	3-15-76	Felson, BCR	Unreadable.
6.	DX 22.25	3-15-76	Spitz, BR, BCR	Unreadable.
7.	DX 22.74.3	3-15-76	Navani, BR, BCR	Mild changes of CWP.
8.	DX 22.25	10-1-80	Wheeler, BR, BCR	Completely Negative; film quality 3 – light.
9.	DX 22.25	10-1-80	Morgan, BR, BCR	Unreadable – markedly underexposed.
10.	DX 22.25	10-1-80	Felson BCR	Completely Negative; film quality 3 – underexposure.
11.	DX 22.25	10-1-80	Spitz, BR, BCR	Unreadable.
12.	DX 22.74.4	10-1-80	Ramakrishnan, BCR	Positive; 1/0 p; small round opacities noted in the lung fields suggestive of pneumoconiosis.
13.	DX 22.25	9-30-81	Wheeler, BR, BCR	Completely Negative; film quality 2 – slight underexposure.
14.	DX 22.25	9-30-81	Morgan, BR, BCR	Completely Negative; film quality 2 – underexposed with light lung bases.
15.	DX 22.25	9-30-81	Felson, BCR	Completely Negative; film quality 2 – underexposed.
16.	DX 22.25	9-30-81	Spitz, BR, BCR	Completely Negative; film quality 3 – underexposed.
17.	DX 22.74.5	9-30-81	Ramakrishnan, BCR	Positive; 1/0, p; small, round opacities seen in the mid and lower lung zones suggestive of pneumoconiosis.
18.	DX 22.25	1-14-83	Wheeler, BR, BCR	Completely Negative; film quality 1; no change since last exam.
19.	DX 22.25	1-14-83	Morgan, BR, BCR	Completely Negative; film quality 1.
20.	DX 22.25	1-14-83	Felson, BCR	Negative; film quality 1; questionable enlargement of hilum, not pneumoconiosis.
21.	DX 22.25	1-14-83	Spitz, BR, BCR	Negative; film quality 2 – underexposure; questionable enlargement of the left hilum.
22.	DX 22.26	1-14-83	Ramakrishnan, BCR	Normal chest, lungs clear.
23.	DX 22.39	4-8-83	Scott, BR, BCR	Completely Negative; film quality 1.
24.	DX 22.39	4-8-83	Wheeler, BR, BCR	Completely Negative; film quality 2 – light PA.
25.	DX 22.43.8	4-8-83	Felson, BCR	Completely Negative; film quality 3 – too light.

[15] The abbreviations above are used to designate physician's qualifications: "B" for "B-reader," "BCR" for "Board-certified Radiologist" and "BCP" for "Board-certified Pulmonologist."

26.	DX 22.43.9	4-8-83	Spitz, BR, BCR	Unreadable.
27.	DX 22.18	11-22-83	Gaziano, BR, BCP	Positive; 1/0, s; size of large opacities is 0; film quality 1.
28.	DX 22.19	11-22-83	Ramakrishnan, BCR	Positive; 1/1, p; small round opacities seen in mid and lower lung zones suggestive of pneumoconiosis; film quality 1.
29.	DX 22.43.2	11-22-83	Halbert, BR, BCR	Completely Negative; film quality 1.
30.	DX22.43.3	11-22-83	Poulos, BR, BCR	Completely Negative; film quality 1.
31.	DX 22.43.4	11-22-83	Felson, BCR	Completely Negative; film quality 2.
32.	DX 22.43.5	11-22-83	Spitz, BR, BCR	Completely Negative; film quality 2 – slightly underexposed.
33.	DX 22.43.6	11-22-83	Wheeler, BR, BCR	Completely Negative; film quality 2 – light bases.
34.	DX 22.43.7	11-22-83	Scott, BR, BCR	Completely Negative; film quality 1.
35.	DX 22.31	4-11-85	Byers, BR	Positive; 1/0, s/s.
36.	DX 22.33	4-11-85	Morgan, BR, BCR	Negative; film quality 1; few calcified granulomata.
37.	DX 22.33	4-11-85	Wheeler, BR, BCR	Completely Negative; film quality 2 – light.
38.	DX 22.35	4-11-85	Felson, BCR	Completely Negative; film quality 1.
39.	DX 22.35	4-11-85	Wiot, BR, BCR	Completely Negative; film quality 2 – light.
40.	DX 22.101	2-4-88	Scott, BR, BCR	Completely Negative; film quality 1.
41.	DX 22.102	2-4-88	Fino, BR, BCP	Negative; film quality 1.
42.	DX 22.103	2-4-88	Wheeler, BR, BCR	Negative; film quality 1; decreased lung markings in right upper lung and apex, more than in left upper lung and compatible with emphysema.
43.	DX 22.48	2-4-88	Sargent, BR, BCP	Positive; 1/0, s/t.
44.	DX 22.83.4	3-26-90	Mullens, BCR	Mild pulmonary hyperinflation, otherwise normal chest.
45.	DX 22.89	3-26-90	Wiot, BR, BCR	Completely Negative; film quality 2 – dark.
46.	DX 22.90	3-26-90	Spitz, BR, BCR	Negative; film quality 2 – dark; decreased vascularity in upper lobes.
47.	DX 22.93	3-26-90	Fino, BR, BCP	Completely Negative; film quality 2 – dark.
48.	DX 22.83.3	6-13-90	Mullens, BCR	Pulmonary hyperinflation, right basalar plate like atelectasis with ill defined infiltrate consistent with pneumoconiosis.
49.	DX 22.87	6-13-90	Wiot, BR, BCR	Negative; film quality 2 – dark.
50.	DX 22.88	6-13-90	Spitz, BR, BCR	Negative; film quality 1; decreased vascularity in upper lobes.
51.	DX 22.92	6-13-90	Fino, BR, BCP	Completely Negative; film quality 2 – dark.
52.	DX 22.62.5	6-25-90	Wolfe, BCR	COPD, probably bronchitis, no active infiltrate.
53.	DX 22.66.2	6-25-90	Wershba, BR, BCR	Unreadable – underexposed.
54.	DX 22.66.3	6-25-90	Abramowitz, BR, BCR	Unreadable – too light.
55.	DX 22.66.4	6-25-90	Hayes, BR, BCR	Unreadable – grossly underexposed.
56.	DX 22.69	6-25-90	Sargent, BR, BCR	Negative; film quality 3 – underexposed.
57.	DX 22.83.2	6-10-92	Epling, BCR	Pulmonary hyperinflation, increased interstitial prominence since 3-26-90.
58.	DX 22.85	6-10-92	Wiot, BR, BCR	Completely Negative; film quality 3 – dark.
59.	DX 22.86	6-10-92	Spitz, BR, BCR	Negative; film quality 1; decreased vascularity in upper lobes.

60.	DX 22.91	6-10-92	Fino, BR, BCP	Completely Negative; film quality 3 – dark.
61.	DX 22.82.2	8-4-92	Fino, BR, BCP	Negative; film quality 1; increased markings at bases – smoking.
62.	DX 22.84.2	8-4-92	Wiot, BR, BCR	Completely Negative; film quality 2 – light.
63.	DX 22.84.3	8-4-92	Spitz, BR, BCR	Negative; film quality 1; possible emphysema.
64.	DX 22.96	8-4-92	Sargent, BR, BCR	Positive; 1/0, s/t; no large opacities; film quality 1; x-ray changes consistent with asbestos exposure or tobacco abuse as opposed to CWP.
65.	EX 24	4-5-96	Fino, BR, BCP	Completely Negative; film quality 1.
66.	EX 8	4-5-96	Scott, BR, BCR	Negative; film quality 2 – underexposure; decreased upper lung markings, probably emphysema.
67.	EX 11	5-26-98	Wheeler, BR, BCR	Negative; film quality 1; probable emphysema with decreased upper lung markings.
68.	EX 9	12-9-98	Scott, BR, BCR	Negative; film quality 2 – underexposure; probable emphysema with decreased upper lung markings.
69.	EX 25	12-9-98	Fino, BR, BCP	Completely Negative; film quality 1.
70.	EX 10	12-2-99	Scott, BR, BCR	Negative; film quality 1; right upper lung infiltrate – either tuberculosis or bacterial pneumonia – and emphysema.
71.	EX 19	12-2-99	Fino, BR, BCP	Negative; film quality 1; right upper lobe nodular densities seen, changes new since April 5, 1996 film.
72.	EX 7	4-3-00	Wheeler, BR, BCR	Negative; film quality 1; moderate to coarse cavitary infiltrate in right upper lung compatible with tuberculosis or advanced bacterial pneumonia and probable emphysema with decreased left upper lung markings; no silicosis or CWP.
73.	EX 20	4-3-00	Fino, BR, BCP	Negative; film quality 1; increased nodule densities seen in right upper lobe, changes worsened since December 2, 1999 film.
74.	DX 9	6-28-00	Patel, BR, BCR	Positive, 1/1, s/t; size of large opacities is 0; film quality 2 – slight overexposure; lungs mildly hyperinflated, extensive bilateral bullous changes, mild chronic obstructive pulmonary disease and right upper lobe infiltrate indicating neoplasia.
75.	DX 10	6-28-00	Barrett, BR, BCR	Positive, 1/1, p/p; size of large opacities is 0; film quality 2 – increased overexposure; possible infiltrate mass.
76.	EX 13	6-28-00	Wheeler, BR, BCR	Negative; film quality 1; moderate infiltrate in right upper lung compatible with tuberculosis or other bacterial pneumonia, no silicosis, CWP or other change.
77.	EX 14	6-28-00	Scott, BR, BCR	Negative; film quality 1; right upper lobe infiltrate – either tuberculosis or other

				bacterial pneumonia – and emphysema.
78.	EX 21	6-28-00	Fino, BR, BCP	Negative; film quality 1; slight improvement of right upper lobe nodular densities since April 3, 2000 film.
79.	EX 15	8-10-00	Scott, BR, BCR	Negative; film quality 1; right upper lobe infiltrate – probably tuberculosis, possibly bacterial pneumonia – and emphysema.
80.	EX 22	8-10-00	Fino, BR, BCP	Negative; film quality 1; no changes in right upper lobe since June 28, 2000 x-ray.
81.	EX 12	1-11-01	Wheeler, BR, BCR	Negative; film quality 3 – moderate overexposure; coarse infiltrate in right upper lung along with a few linear and irregular scars compatible with tuberculosis and emphysema with hyperinflation.
82.	EX 26	1-11-01	Fino, BR, BCP	Unreadable.
83.	EX 2	3-12-01	Hippensteel, BR, BCP	Negative; film quality 2 – mild hazy in periphery; infiltrate, scarring and cavity/bullous formation from prior fungal infection.
84.	EX 16	3-12-01	Scott, BR, BCR	Negative; film quality 2 – slight underexposure; possible bacterial pneumonia, right upper lobe infiltrate possibly due to tuberculosis and emphysema.
85.	EX 17	3-12-01	Wheeler, BR, BCR	Negative; film quality 2 – underexposure in mid and lower lungs; mixed linear and irregular infiltrate in right upper lung and superior segment in left lower lung compatible with tuberculosis, probable minimal pleural fibrosis and emphysema with decreased left upper lung markings.
86.	EX 23	3-12-01	Fino, BR, BCP	Negative; film quality 1; right upper lobe nodular infiltrates have improved since June 28, 2000 film.

Pulmonary Function Tests

	Exhibit No.	***Test Date***	***Physician***	***FEV1***	***FVC***	***MVV***	***TR***	***Age/Ht.***	***Coop./ Comp.***
1.	DX 22.99	3-30-83	Buddington	3.20	4.62	107	Y	39/69.25"	Good
	Post-Bronchodilator			-----	-----	----			
	Comments:	Slight obstructed airway.							
2.	DX 22.12	11-21-83	Kanwal	2.36	3.56	95	Y	40/70"	Good
	Post-Bronchodilator			-----	-----	---			
3.	DX 22.13	11-22-83	Zaldivar	INVALID					
	Post-Bronchodilator								
4.	DX 22.16	6-19-84	Kanwal	2.81	4.13	86	Y	41/70"	Good
	Post-Bronchodilator			-----	-----	---			
	Comments:	Mild obstructive pulmonary disease.							
5.	DX 22.27	11-16-84	Kanwal	2.94	3.59	90	Y	41/70"	Good

	Post-Bronchodilator			-----	-----	---			
6.	DX 22.28	11-16-84	Gaziano	NOTHING REPORTED					
	Post-Bronchodilator								
7.	DX 22.31	4-11-85	Sargent	3.34	4.90	145	Y	41/68"	Good
	Post-Bronchodilator			2.78	4.16	137	Y		
	Comments:	Mild obstructive ventilatory impairment and a decrease in diffusing capacity.							
8.	DX 22.83.6	10-26-87	Robinette	2.91	4.70	----	Y	44/68"	Good
	Post-Bronchodilator			-----	-----	----			
	Comments:	Normal spirometry with evidence of diminished FEF 25 – 75, suggestive of changes in the small airways.							
9.	DX 47.2	1-29-88	Robinette	2.87	4.53	85	Y	44/68"	-------
	Post-Bronchodilator			-----	-----	---			
10.	DX 22.48	2-4-88	Sargent	2.91	4.25	---	Y	44/69"	Good
	Post-Bronchodilator			3.02	4.48	---	Y		
	Comments:	Mild diffusing obstructive lung disease with reduction in DLCO, possibly due to carboxyhemoglobin anemia.							
11.	DX 22.62.2	6-13-90	Robinette	2.40	4.26	82	Y	47/68"	Good
	Post-Bronchodilator			2.44	4.38	72	Y		
	Comments:	Mild obstructive lung disease. Resting hypoxemia. Compared to 1-29-88, interval decreased in lung function.							
12.	DX 22.95	8-4-92	Sargent	2.21	3.64	---	Y	49/72"	Good
	Post-Bronchodilator			-----	-----	---			
	Comments:	No restriction.							
13.	DX 104.2	4-1-93	Sargent	2.06	4.13	75	Y	49/69"	Fair
	Post-Bronchodilator			2.03	4.20	---	Y		
	Comments:	Moderate obstructive ventilatory impairment unresponsive to bronchodilator. Pulmonary functions consistent with a combination of chronic bronchitis and pulmonary emphysema.							
14.	DX 5	6-28-00	Rasmussen	1.75	4.22	44	Y	57/68"	Good
	Post-Bronchodilator			1.89	4.27	56			
	Comments:	Moderate, irreversible obstructive ventilatory impairment. Maximum breathing capacity is markedly decreased (predicted 139 which is less than the calculated values of 70 and 76). Single breath carbon monoxide diffusing capacity is markedly decreased. Minimal resting hypoxia.							
15.	DX 8	6-28-00	Michos	1.75	4.22	44	Y	57	Good
	Post-Bronchodilator			-----	-----	----			
	Comments:	Suboptimal MVV performance.							
16.	EX 3	3-12-01	Hippensteel	1.51	3.09	49	Y	57/69"	-------
	Post-Bronchodilator			1.59	3.40	----			
	Comments:	Spirometry shows severe airflow obstruction with minimal improvement post-bronchodilator. MVV is severely reduced. Lung volumes show some air trapping. Diffusion reduced, but only mildly when corrected for volume inhaled.							

Blood Gas Tests

	Exhibit No.	***Test Date***	***Physician***	***PO2***	***PC02***
1.	DX 22.12	11-21-83	Kanwal	61.2	33.9
	Exercise if Administered:			75.9	32.9
	Predicted Normal Range:			-----	-----
2.	DX 22.14	11-21-83	Zaldivar		

	Exercise if Administered:				
	Predicted Normal Range:				
	Comments:	Reviewed Dr. Kanwal's 11-21-83 test and found it to be ACCEPTABLE.			
3.	DX 22.100	4-5-84	Humana	71.0	34.0
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
4.	DX 22.31	4-11-85	Sargent	69.7	32.5
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
	Comments:	Hypoxemia, carboxyhemoglobin elevated, polyeythemia consistent with chronic tobacco abuse or other carbon monoxide contact.			
5.	DX 47.3	1-29-88	Robinette	73.0	30.3
	Exercise if Administered:			80.0	32.4
	Predicted Normal Range:			-----	-----
6.	DX 22.48	2-4-88	Sargent	71.3	34.4
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
7.	DX 22.68.3	6-13-90	Robinette	62.0	35.1
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
8.	DX 22.67	6-13-92	Lantos		
	Exercise if Administered:				
	Predicted Normal Range:				
	Comments:	Reviewed Dr. Robinette's 6-13-90 test and found it to be VALID.			
9.	DX 22.83.5	6-10-92	Robinette	70.0	38.5
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
10.	DX 22.97	8-4-92	Sargent	66.0	38.0
	Exercise if Administered:			-----	-----
	Predicted Normal Range:			-----	-----
11.	DX 21.3	9-11-97	Robinette	72.0	37.3
	Exercise if Administered:			70.0	36.1
	Predicted Normal Range:			-----	-----
12.	DX 7.1	6-28-00	Rasmussen	64.0	37.0
	Exercise if Administered:			53.0	37.0
	Predicted Normal Range:			73 – 101	37 – 44
13.	DX 8	6-28-00	Michos		
	Exercise if Administered:				
	Predicted Normal Range:				
	Comments:	Reviewed Dr. Rasmussen's 6-28-00 test and found it to be VALID.			
14.	EX 5	3-12-01	Hippensteel	60.0	37.7
	Exercise if Administered:			57.8	32.6
	Predicted Normal Range:			-----	-----
	Comments:	Mild to moderate hypoxemia. Carboxyhemglobin level is elevated consistent with continued smoking.			

Relevant Examination and Medical Reports

	Exhibit No.	*Physician and Qualifications*	*Exam Date*
1.	DX 22.32	Dr. Catron	3-22-83

Comments: Claimant complained of having increased amount of episodes of breathing difficulty and shortness of breath, particularly with exercise and exertion. Claimant stated that he continues to smoke a pack of cigarettes daily. Dr. Catron noticed that Claimant has no marked respiratory disease.

Conclusions: Claimant probably has moderately advanced emphysema. Claimant has been advised that he needs to lose weight and stop smoking.

2.	DX 22.17	Dr. Kanwal	11-21-83

Comments: Dr. Kanwal's medical report was based on his examination and EKG of Claimant. At the examination, Dr. Kanwal reviewed with Claimant his employment history, which included his 18.46 years in coal mine employment, and his individual medical history, as well as his family's medical history. Claimant stated that he has smoked 1 pack of cigarettes a day for over 20 years. Upon examination, Dr. Kanwal noted that Claimant has problems with coughing and wheezing, as well as sputum and dyspnea.

Conclusions: Claimant has chronic bronchitis and coal workers' pneumoconiosis which are related to his prolonged coal dust exposure.

3.	DX 22.31	Dr. Sargent B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	4-11-85

Comments: Dr. Sargent's medical report was based on his interview and examination of Claimant which included a complete history of past and present illnesses, employment history, a review of symptoms and a physical examination. An EKG was performed and showed a left atrial enlargement and a left axis deviation, but no evidence of right ventricular enlargement or right atrial enlargement. Dr. Sargent noted that Claimant's chest x-ray was done and interpreted by Dr. Byers, a B Reader, as being consistent with very mild coal workers' pneumoconiosis with a profusion of 1/0, s/s. Pulmonary function testing revealed a mild obstructive ventilatory impairment with a rather marked decrease in diffusing capacity, which is consistent with mild pulmonary emphysema. Arterial blood gas studies revealed mild hypoxemia with moderate widening of the alveolar to arterial oxygen gradient.

Conclusions: Claimant suffers from a mild pulmonary impairment as evidenced by decreased terminal flow rates on spirometry that is due to smoking cigarettes and perhaps some mild asthma. He also has chest x-ray evidence of very mild CWP; however, they are not severe enough to explain in any of his blood gas or pulmonary function abnormalities. None of Claimant's abnormalities are due to exposure to coal dust.

4.	DX 22.36	Dr. Sargent B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	5-7-85

Conclusions: Dr. Sargent opined that Claimant's arterial blood gas and ventilation abnormalities are not severe enough to preclude him from returning to coal mine employment.

5.	DX 22.44.2	Dr. Robinette B Reader, Board Certified in Internal Medicine,	8-15-87

with Subspecialty in Pulmonary Disease

Comments: Dr. Robinette's medical report is contained in a letter to Claimant's attorney. Claimant, in each visit with Dr. Robinette, has complained of persistent cough with sputum production, congestion and shortness of breath.

Conclusions: Claimant's physical examination demonstrated moderate air flow obstruction with scattered wheezes and rhonchi heard. Claimant has persistent bronchitis with chronic air flow obstruction. Dr. Robinette believes that Claimant has CWP with a moderately severe ventilatory defect, which has been documented as being hypoxemic in the past. It is Dr. Robinette's opinion that Claimant's pulmonary disease is irreversible and that he does have underlying CWP contributing to his current respiratory symptoms.

6. DX 22.48 Dr. Sargent 2-4-88
B Reader, Board Certified in Internal Medicine,
with Subspecialty in Pulmonary Disease

Comments: Dr. Sargent based his February 4, 1988 medical report on Claimant's medical and occupational history and his physical examination of Claimant which included pulmonary function and arterial blood gas studies, ECG tracings and an x-ray report. Claimant stated that he has been a miner for 19 years and now smokes 2 packs of cigarettes per day (has smoked for 28 years). Claimant stated that his breathing has been getting slowly worse, to the point where he can only walk up 2 flights of stairs or only go about 5 minutes on the treadmill. Claimant has cough production of about 1/4 cup of yellow to green phlegm per day without blood. Claimant wheezes just about all the time which is made worse by hair spray or dust. Claimant has occasional sharp pain in his upper anterior chest which can last from a few minutes to hours.

Conclusions: Claimant's 19 years of coal mine employment rule out significant CWP. Claimant has chronic bronchitis and probable COPD from long-term cigarette abuse.

7. DX 22-41 Dr. Robinette 2-5-88
B Reader, Board Certified in Internal Medicine,
with Subspecialty in Pulmonary Disease

Comments: Claimant's complained of cough and congestion.

Conclusions: Claimant has chronic bronchitis, airway obstruction and CWP.

8. DX 22.48 Dr. Sargent 2-12-88
B Reader, Board Certified in Internal Medicine,
with Subspecialty in Pulmonary Disease

Comments: Dr. Sargent's medical report included a copy of his physical examination of Claimant, Claimant's past and present illness history and family history, his occupational history, social history and a review of his symptoms. Claimant's EKG showed left axis deviation which was otherwise normal. Claimant's chest x-ray was read as equivocal, but probably positive for the presence of an occupational pneumoconiosis. The profusion reading was 1/0, s/t. However, Dr. Sargent noted that while such a reading could be consistent with the presence of an occupational pneumoconiosis, it is more often consistent with the presence of asbestosis or cigarette smoking. Claimant's pulmonary function tests were consistent with a mild obstructive ventilatory impairment with diminished diffusing capacity. The diminished diffusing capacity was in part due to the presence of an elevated caboxyhemoglobin level at the time of the study. No evidence of a restrictive impairment on the pulmonary function tests. The arterial blood gases showed mild

hypoxemia with mild hyperventilation on room air.

Conclusions: Dr. Sargent's overall impression was that Claimant does not suffer from CWP. Despite having a positive x-ray, Claimant's changes are not the changes that are usually seen with CWP and therefore Dr. Sargent opined that such changes are due to Claimant's long-term cigarette smoking. Claimant's pulmonary function tests also do not support the diagnosis of a ventilatory impairment on the basis of CWP since he does not have a purely obstructive impairment without evidence of restriction. Once again, Dr. Sargent opined this to be completely consistent with Claimant's history of cigarette abuse. As for Claimant's ventilatory impairment, neither the severity of his blood gas abnormalities, nor the severity of his airway obstruction would preclude him from doing any job required in the mining of coal from purely a respiratory standpoint.

9. DX 22.62.7 Dr. Bailey 6-25-90

Comments: Dr. Bailey's medical report is in the form of chart notes from his June 25, 1990 and July 25, 1990 appointments with Claimant. Claimant stated in the June 25th notes that he has shortness of breath, pneumonia, cough and congestion. However, Dr. Bailey noted that Claimant's chest x-ray shows no pneumonia. One month later, in the July 25th notes, Claimant stated that his breathing was better.

10. DX 22.62.4 Dr. Bailey 11-7-90

Comments: Dr. Bailey's medical report consists of his examination of Claimant on June 25th and July 25th of 1990. In his report, Dr. Bailey noted that Claimant presented with shortness of breath, cough and congestion. Claimant underwent a chest x-ray which, according to Dr. Bailey, showed chronic diffuse fibrosis with accentuated bronchovascular markings consistent with bronchitis and COPD. It was also noted that Claimant had elevated hemoglobin and hematocrit consistent with polycythemia secondary to his lung disease.

Conclusions: Claimant appears to have advanced pulmonary disease with evidence of severe emphysema on his chest x-ray and polycythemia. As for his black lung, Dr. Bailey opined that it is probably substantial and agrees that Claimant should be considered for black lung benefits.

11. DX 22.94 Dr. Sargent 8-12-92
B Reader, Board Certified in Internal Medicine,
with Subspecialty in Pulmonary Disease

Comments: This medical report is a follow-up of Dr. Sargent's August 4, 1992 interview and examination of Claimant. Dr. Sargent included the following in his report: Dr. Sargent's history and physical examination of Claimant, history of Claimant's past and present illnesses, Claimant's family history, Claimant's social history, a review of symptoms and Claimant's employment history. Claimant underwent an EKG which showed a far left axis with loss of posterior forces in V1 and V2. Claimant's chest x-ray was categorized as profusion 1/0, s/t. Additionally, abnormal opacities were present in the mid and lower lung zones, but there were no changes from the films dated 2-4-88 and 4-11-85. Claimant's pulmonary function tests showed a moderate obstructive ventilatory impairment and his arterial blood gases showed a PO2 of 66, with PCO2 of 38 and pH of 7.43.

Conclusions: Claimant is not suffering from CWP. This determination is based on the character of Claimant's chest x-ray changes, his ventilatory abnormality and the progression of his ventilatory impairment. Claimant's chest x-ray is of very low profusion, with s and t opacities in the bases. However, CWP causes opacities of the p, q and r variety that are predominantly in the upper lung zones. The 1/0, s/t reading is much more consistent with asbestos exposure or cigarette smoking, which is certainly plausible.

Claimant has a moderate obstructive ventilatory impairment. Dr. Sargent noted that there has been a definite progression in this impairment since the pulmonary functions done in 1985 and those done in 1988. According to Dr. Sargent, since Claimant quit coal mining in 1982, one would not expect progression of the ventilatory abnormalities between 1985 and 1992 to have been due to coal dust exposure. For this reason, Dr. Sargent opined that Claimant's current ventilatory abnormality is due to his ongoing cigarette abuse, to which continued smoking would cause further deterioration in lung function. Claimant's blood gases show moderate hypoxemia, but in the past, they've been shown to improve with exercise. This moderate hypoxemia in and of itself is not disabling because Claimant's blood remains greater than 90% saturated with oxygen. Finally, Dr. Sargent suggested that Claimant retains the respiratory capacity to do his last job as a shuttle car operator.

12.	DX 22.106	Dr. Fino B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	4-12-93

Comments: Dr. Fino based his medical report on Claimant's work history and background information, as well as an extensive review of Claimant's chest x-rays, pulmonary function studies, arterial blood gas tests and various physical examinations.

Conclusions: There is insufficient objective medical evidence to justify a diagnosis of simple CWP. Claimant does not suffer from an occupationally acquired pulmonary condition. Claimant has a moderate obstructive ventilatory defect secondary to smoking. If Claimant is indeed required to lift rock dust bags weighing 50 pounds up to 400 times per day, Claimant could no longer perform his last job. All of Claimant's respiratory abnormality is related to cigarette smoking. Lastly, Claimant's respiratory condition would be no different had he never stepped foot in the coal mines.

13.	DX 22.105	Dr. Branscomb B Reader, Board Certified in Internal Medicine	4-13-93

Comments: Dr. Branscomb's medical report includes Claimant's present and past illnesses, his work history and background information, physician depositions and an extensive review of Claimant's past chest x-rays, pulmonary function studies, arterial blood gas test and physical examinations prior to the date of Dr. Branscomb's medical report, dated April 13, 1993.

Conclusions: Claimant suffers from neither clinical, nor legal pneumoconiosis. His disease in every respect is identical to what one would have expected had he never been involved in coal mining. Claimant has mild impairment, consisting of mild airways obstruction and air trapping. Presently, Claimant probably has sufficient pulmonary function to operate a shuttle car. Claimant would probably enjoy marked improvement with total cessation of smoking, coupled with weight reduction. Claimant has no impairment secondary to, nor aggravated by coal dust.

14.	EX 18	Dr. Fino B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	1-3-00

Comments: Dr. Fino's medical report is based on his review of Claimant's January 3, 2000 CT scan. Upon review, Dr. Fino noted that Claimant had no pleural or parenchymal abnormalities consistent with occupational pneumoconiosis. Dr. Fino did state that there were significant bullae and emphysema seen throughout the lungs, in addition to an infiltrate in the right upper lobe.

Conclusions: There were no changes consistent with a coal mine dust associated occupational lung

disease. However, changes were seen in the right upper lobe, which represented infected bullae, emphysema or tuberculosis.

15.	DX 21.2	Dr. Robinette B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	6-12-00

Comments: Dr. Robinette's medical report was made as a result of his follow-up examination of Claimant for his necrotizing pneumonia with an apparent superimposed fungal infection. In his report, Dr. Robinette that Claimant had undergone 6 months of Sporanex therapy. Claimant had no recurrent fever and denied any change in cough or sputum production. Claimant's chest on auscultation revealed diminished breath sounds with bilateral wheezes and inspiratory crackles were present at both bases. Claimant's heart was regular and his extremities showed no edema. Dr. Robinette recommended that Claimant discontinue Eldertonic and Sporanox treatment. Lastly, Dr. Robinette notes that he again discussed the importance of smoking cessation with Claimant.

17.	DX 6	Dr. Rasmussen B Reader; Board Certified in Internal Medicine	6-28-00

Comments: Dr. Rasmussen's medical report is based on his physical examination and laboratory tests of Claimant, as well as his review of Claimant's chest x-ray performed by Dr. Patel, which Dr. Rasmussen indicates as being positive for pneumoconiosis, as well as a right upper lobe mass suggesting neoplasia. Dr. Rasmussen noted that Claimant was employed for 19 years in coal mines and began to smoke regularly in 1969, averaging 2 packs of cigarettes per day until he quit on June 23, 2000. Dr. Rasmussen reviewed Claimant's past medical history which included: poor hearing, heartburn and indigestion, lightheadedness with coughing paroxysms – Claimant passed out on 1 occasion and pain and stiffness in the left hip pain and both knees. Upon reviewing Claimant's EKG, Dr. Rasmussen's concluded that Claimant had a right bundle branch block and evidence of right ventricular hypertrophy. Claimant underwent a pulmonary function study and an arterial blood gas test, to which the findings of Dr. Rasmussen are noted above. Following his examination, Dr. Rasmussen listed Claimant's impairments as follows: chronic productive cough, airflow obstruction, reduced SBDLCO and marked impairment in oxygen transfer during light and moderate exercise.

Conclusions: Claimant's lab studies reveal a marked loss of lung function as reflected by his ventilatory impairment, of which the degree of impairment renders the Claimant totally disabled for any significant gainful employment. Dr. Rasmussen further concluded that Claimant has coal workers' pneumoconiosis (CWP) and chronic obstructive pulmonary disease (COPD)/emphysema.

Etiology: Dr. Rasmussen noted that Claimant had two risk factors for his severe lung diseases (CWP and COPD/Emphysema) – cigarette smoking and coal mine dust exposure. Of the two risk factors, Dr. Rasmussen concluded that Claimant's coal mine dust exposure is a significant contributing factor.

18.	EX 1	Dr. Hippensteel B Reader, Board Certified in Internal Medicine, with Subspecialty in Pulmonary Disease	3-12-01

Comments: Dr. Hippensteel's medical report is based on an extensive review of Claimant's entire black lung file, which includes medical reports and letters, office notes and physician depositions dating back to March of 1983. Dr. Hippensteel also reviewed 66 interpretations of Claimant's 16 chest x-rays, dating back to March 25, 1976, as well as 10 arterial blood gas and 13 pulmonary function studies performed on Claimant. Dr. Hippensteel noted that Claimant worked in the mines for a total of 19 years until 1982 when

the mines were forced to close; however, Claimant stated that he was told by Dr. Robinette that he could not go back to work in the mines because of his breathing. Dr. Hippensteel reported Claimant's medical history to include: a stroke in 1989 that affects his memory, circulation problems in his lower extremities resulting in medication, arthritis, nerve troubles, stomach problems resulting in medication, breathing problems requiring the use of medication, recurring pneumonia, broken left hip, broken left ankle/leg and asthma. Furthermore, Claimant asserted that he could only walk about 30 feet before getting out of breath. At time of examination, Claimant was smoking 2 packs of cigarettes a day since he was 16 years of age. Dr. Hippensteel interpreted Claimant's chest x-ray as negative for pneumoconiosis with a classification of 0/0; however, Claimant has infiltrate, scarring and cavity/bullous formation in his right upper lobe as a result of a prior fungal infection. Claimant's lab studies show that he has severe airflow obstruction with minimal improvement post-bronchodilator and his EKG at rest shows left axis deviation with possible left anterior hemiblock in addition to possible right ventricular hypertrophy.

Conclusions: Claimant suffers from various pulmonary impairments related chronic bronchitis that were reversible enough at times to show normal function, while at times showing significant impairment. Claimant has functional disturbances that occurred during times of continued, heavy smoking. Claimant has no evidence of coal workers' pneumoconiosis as a cause for his pulmonary impairment. Claimant's additional medical problems – arthritis, hypertension, peripheral vascular disease, prior stroke and nerve trouble – give him the additional impairment that make him unable to go back to his job. The record shows that Claimant is now disabled from a pulmonary standpoint, in addition to other medical problems, so that he cannot return to work.

Etiology: Claimant has developed a significant pulmonary impairment which relates to his severe fungal infection and smoking history, rather than his coal dust exposure. Claimant has no evidence of coal workers' pneumoconiosis. Instead, the evidence shows, with a reasonable degree of medical certainty, that Claimant would have been just as ill from the same problems had he never been exposed to coal dust.

Discussion

Total Disability

Because this matter involves a duplicate claim, it is first necessary to evaluate whether the Claimant can establish a material change in condition since the denial of his prior claim. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Section 718.204(b)(2) provides the following methods for establishing total disability: (1) qualifying pulmonary functions tests; (2) qualifying arterial blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony.[16]

a. Pulmonary Function Tests

As previously stated, total disability may be established with qualifying pulmonary function studies. The pulmonary function study, also referred to as a ventilatory study or spirometry, measures obstruction in the airways of the lungs. The greater the resistance to the flow of air, the more severe any lung impairment. A pulmonary function study does not indicate the existence of pneumoconiosis; rather, it is employed to measure the level of the miner's disability. In performing the study, the miner is

[16] The Board has held that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. ***Tedesco v. Director, OWCP,*** 18 B.L.R. 1-103 (1994).

required to blow hard into a mouthpiece which is connected to a flowmeter. The spirometer records the amount of air expired over a period of time onto tracings which must be included in the miner's case record. The regulations require that this study be conducted three (3) times to assess whether the miner exerted optimal effort among trials, ***Estes v. Director, OWCP,*** 7 B.L.R. 1-414 (1984), but the Board has held that a ventilatory study which is accompanied by only two (2) tracings is in "substantial compliance" with the quality standards at §§ 718.204(c)(1). ***Defore v. Alabama By-Products Corp.,*** 12 B.L.R. 1-27 (1988). Furthermore, the administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. ***Houchin v. Old Ben Coal Co.,*** 6 B.L.R. 1-1141 (1984); ***Runco v. Director, OWCP,*** 6 B.L.R. 1-945 (1984). It is important to realize that, if the miner does have a pulmonary or respiratory impairment, undergoing such test may be very painful, and the miner may be unable to complete the test due to coughing or shortness of breath.

As an individual ages, his or her lung capacity lessens. Differences in lung volume have also been noted between men and women of the same age and height. As a result, tables of data based upon the miner's age, height and gender are used to determine whether the study has produced qualifying results. To qualify under the regulations, the FEV_1 and either the MVV or FVC values must be equal to or less than the appropriate values set out in the tables at 20 C.F.R. Part 718, Appendix B for a miner of similar age, gender and height.[17]

Claimant underwent three pulmonary function tests since his last application for benefits was denied (DX 5, DX 8 and EX 3). Each of Claimant's tests are qualifying under the regulations at 20 C.F.R. § 718.204 (b)(2), App. B (Id). Therefore, based on these qualifying pulmonary function tests, Claimant is totally disabled under the Act.

b. Blood Gas Studies

Section 718.204(b)(2)(ii) provides that a claimant may prove total disability through evidence of qualifying blood gas studies. Moreover, Claimant's arterial blood gas levels must correspond to the values in Appendix C. 20 C.F.R. § 718.204(b)(2). According to Appendix C, for tests conducted at sites up to 2,999 feet above sea level, the sum of Claimant's PCO2 and PO2 levels must be equal to or less than 100 mm Hg.

Claimant underwent four (4) blood gas studies since his last application for benefits was denied. Of the four studies, the only study that qualifies Claimant as totally disabled[18] was performed by Dr. Hippensteel on March 12, 2001 (EX 5). Because of the lapse of time between Claimant's first study (September 11, 1997) and last study (March 12, 2001), I give very little weight to the first blood gas study performed by Dr. Robinette. As for the two studies sandwiched between Claimant's four (4) blood gas studies, they both produced non-qualifying results (DX 7, DX 8).

In the end, I am left with one (1) qualifying blood gas study, which is the most recent test, and

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[17] Based upon the record, the Claimant's height is 68.5 inches (average between the three reported heights).

[18] The sum of Claimant's PCO2 and PO2 levels equaled 97.7 mm Hg (EX 5).

two (2) non-qualifying studies performed simultaneously by Drs. Rasmussen and Michos (DX 7, DX 8 and EX 5). Because none of the three (3) tests, whether looked at separately or coupled together, are persuasive enough, Claimant has failed to carry his burden of establishing total disability pursuant to blood gas study evidence.

c. Evidence of Cor Pulmonale

Under section 718.204(b)(2)(iii), total disability may be proven through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

d. Physician Opinion Evidence

Lastly, the regulations provide that a claimant may prove total disability where a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(iv). The Claimant must first compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. ***Schetroma v. Director, OWCP,*** 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding for total disability is made, thereby shifting the burden to the party opposing entitlement to prove that the claimant is able to perform gainful and comparable and gainful work, as defined pursuant to 20 C.F.R. § 718.204(b)(2). ***Taylor v. Evans and Grambrel Co.,*** 12 B.L.R. 1-83, 1-87 (1988).

Claimant alleges that he has not worked in the coal mine industry since he broke his leg in March of 1982 (DX 22-107A). Before his work-related injury, Claimant worked as a shuttle car operator which required him to sit and operate a shuttle car in order for the coal to be hauled from the miner to the belt (Id.). Claimant testified that, in addition to operating the shuttle car, he also loaded supplies such as oil, roof bolts and rock dust onto a cart once a day (Id.).[19] At his hearing before Judge Rosenzweig on May 5, 1993, Claimant testified that he was no longer able to lift more than ten (10) pounds before he begins to have problems (Id.). Claimant elaborated by stating that "I can pick up a bag of groceries that weigh almost ten (10) pounds and carry it from [the] road to the house and it ain't thirty (30) feet and I'm out of breath" (Id.).

Conversely, Claimant, on cross-examination, acknowledged that he signed a Description of Coal Mine Work and Other Employment form on October 26, 1983 which essentially characterized his job as sedentary (DX 22-107A, DX 22-109). Furthermore, Claimant testified that the form specifically stated that his job entailed eight (8) hours of sitting, no standing and no crawling (Id.). However, Claimant disputed the fact that his job entailed eight (8) hours of sitting and instead, reaffirmed his earlier testimony that he spent approximately one (1) to two (2) hours daily loading

[19] The rock dust came in 40-50 pound bags, oil came in 16-gallon drums, weighing 160 pounds, and the roof bolt bundles weighed about 30 pounds (DX 22-107A).

supplies (Id.).

In comparing the exertional requirements of his last coal mining job with the physical limitations demonstrated on record, it is determined that Claimant has established that he is totally disabled pursuant to 20 C.F.R. § 718.204(b)(iv) by a preponderance of the medical evidence on record. In support, Dr. Rasmussen concluded in his medical report that Claimant was totally disabled (DX 6). Furthermore, Dr. Hippensteel testified in his deposition that Claimant is certainly disabled from performing these jobs[20] at this point in time with respect to his respiratory status (EX 27). For reasons set forth below, there is not reason to discount these opinions.

In addition to the above medical opinions, Claimant's most recent pulmonary function tests, which were administered by Drs. Rasmussen and Hippensteel, both resulted in positive findings (DX 5, EX 3). Although he noted that Claimant's MVV performance was suboptimal, Dr. Michos also accepted Claimant's June 28, 2000 pulmonary function test as positive (DX 8). I find Claimant's MVV performance, whether suboptimal or not, to be insignificant and hold the test as positive. Based solely on the pulmonary function tests, Claimant is totally disabled due to a respiratory impairment.

Because the other two (2) medical reports – Dr. Fino (EX 18) and Dr. Robinette (DX 21.2) – submitted subsequent to Claimant's filing of his duplicate claim are silent on the issue of total disability, I give more weight to the medical opinions of Drs. Rasmussen and Hippensteel as to the issue of total disability. Based on physician opinion evidence, as well as pulmonary function tests, Claimant has established by a preponderance of the evidence that he has since become totally disabled from a respiratory perspective.

Having demonstrated that he is now totally disabled from a respiratory perspective, Claimant has established a material change in conditions. According to 20 C.F.R. § 725.309, denial of Claimant's duplicate claim based on the denial of his prior claim is no longer applicable. Instead, I will review the entire record to determine whether Claimant is able to prove all four elements necessary for entitlement of benefits under the Act.

Existence of Pneumoconiosis and its Etiology

1. Existence of Pneumoconiosis

Pneumoconiosis is defined by the Regulations as "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The definition is not confined to 'coal workers' pneumoconiosis,' but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.

This broad definition "effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines." ***Robinson***

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[20] According to Dr. Hippensteel, Claimant's specific job duties included lifting 16-gallon oil barrels, 50-lb. Rock dust bags and roof bolt bundles, as well as working as a shuttle car operator (EX 27).

v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP, 14 B.L.R. 2-68, 2-78 (CA4 1990), 914 4th Cir. 1990), citing ***Rose v. Clinchfield Coal Co.,*** 614 F.2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. ***Robinson v. Director, OWCP,*** 3 B.L.R. 1-798.7 (1981); ***Tokarcik v. Consolidation Coal Co.,*** 6 B.L.R. 1-666 (1983)(chronic bronchitis secondary to coal dust exposure equivalent to CWP); ***Heavilin v. Consolidation Coal Co.,*** 6 B.L.R. 1-1209 (B.R.B. 1984)(emphysema held compensable under the Act). Likewise, chronic obstructive pulmonary disease (COPD) may be encompassed within the legal definition of pneumoconiosis. ***Warth v. Southern Ohio Coal Co.,*** 60 F.3d 173 (4th Cir. 1995)(COPD refers to three disease processes – chronic bronchitis, emphysema and asthma – that are all characterized by airway dysfunction).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by one (1) of the following methods: (1) chest x-ray evidence; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by "other relevant evidence." 20 C.F.R. §§ 410.414(a)-(c).

a. X-Ray Evidence

Section 718.202(a)(1) provides for a finding of the existence of pneumoconiosis with positive chest x-ray evidence, and that "where two or more x-rays are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiographic qualifications of the physicians interpreting such x-rays." 20 C.F.R. § 718.202(a)(1). Positive x-rays may form the basis of a finding of the existence of pneumoconiosis; however, they must be considered in light of all the relevant evidence. I am not to blindly defer to the numerical superiority of x-ray evidence, ***Adkins v. Director, OWCP,*** 958 F.2d 49, 52 (4th Cir. 1992); ***Woodward v. Director, OWCP,*** 991 F.2d 314 (6th Cir. 1993); ***Sahara Coal Co. v. Fitts,*** 39 F.3d 781 (7th Cir. 1994); ***Wilt v. Wolverine Mining Co.,*** 14 B.L.R. 1-70 (1990), although it is within my discretion to do so. ***Edminston v. F & R Coal Co.,*** 14 B.L.R. 1-65 (1990).

Box 2B(c) of the standard x-ray form indicates the quantity of opacities in the lung and therefore, the presence or absence of pneumoconiosis. The more opacities noted in the lung, the more advanced the disease; and there are four (4) categories to which a physician may choose:

> **0** = small opacities absent or less than in category 1;
> **1** = small opacities definitely present, but few in number;
> **2** = small opacities numerous, but normal lung markings still visible;
> **3** = small opacities very numerous and normal lung markings are usually partly or totally obscured.[21]

If no categories are chosen, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis. Likewise, an x-

[21] 20 C.F.R. §§ 718.108 Chest Roentgenograms (x-rays).

ray which is interpreted as Category 0 (–/0, 0/0, or 0/1) demonstrates, at most, only a negligible presence of the disease and will not support a finding of pneumoconiosis under the Act or regulations. 20 C.F.R. § 410.428(c).

If the physician determines that the study is Category 1 (1/0, 1/1 or 1/2), Category 2 (2/1, 2/2 or 2/3) or Category 3 (3/2, 3/3 or 3/+), then there is a definite presence of opacities in the lung and the x-ray report may be used as evidence of pneumoconiosis. An interpretation of 1/0 is the minimum reading under the regulations which will support a finding of pneumoconiosis. A 1/0 reading indicates that the physician has determined that the x-ray is Category 1, but he/she seriously considered Category 0. As for another example, a reading of 2/2 indicates that the physician determined that the x-ray was Category 2 and Category 2 was the only other category seriously considered by the physician.

In this case, the entire record contains twenty-four (24) x-rays, with eighty-six (86) interpretations.[22] A film quality of "1" is good whereas a "U/R" designates that the x-ray film was unreadable. Additionally, if a physician marks a "3," or, in some cases, a "-," then the x-ray study may be accorded little or no probative value as it is of very poor quality. ***Gober v. Reading Anthracite Co.,*** 12 B.L.R. 1-67 (1988). Of the twenty-four (24) x-rays, interpretations of nine (9) fall into the category of unreadable or have a film quality of "3." Being that these x-rays are of very poor quality, I accord no probative value to them.

A review of the remaining radiographic interpretation evidence reveals a conflict in opinion as to whether the Claimant suffers from coal workers' pneumoconiosis (CWP). In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretations favorable and unfavorable may be a factor. ***Wilt v. Wolverine Mining Company,*** 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. ***Akins v. Director, OWCP,*** 958 F.2d 49 (4th Cir. 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. ***Dixon v. North Camp Coal,*** 8 B.L.R. 1-344 (1985); ***Melink v. Consolidation Coal Company,*** 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. ***Taylor v. Director, OWCP,*** 10 BRBS 449, BRB No. 77-610 BLA (1979). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. **McMath v. Director, OWCP,** 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations on one (1) x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present. ***Copley v. Arch of West Virginia, Inc.,*** Case No. 93-1940 (4th Cir. June 21, 1994)(unpublished)

The November 22, 1983 x-ray generated a dispute among the eight (8) doctors who interpreted the film. A certified radiologist (Dr. Ramakrishnan) and a certified pulmonologist (Dr. Gaziano), who is also a "B" reader, found evidence of pneumoconiosis on the film. However, of the

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[22] Claimant underwent 15 x-rays (64 interpretations thereof) prior to his most recent denial of benefits and 9 x-rays (22 interpretations thereof) were performed thereafter.

two (2), only the curriculum vitae of Dr. Gaziano has been admitted into evidence. Therefore, I give less weight to the positive interpretation of Dr. Ramakrishnan. On the other hand, six (6) physicians interpreted the x-ray as negative. Of the six (6), five (5) are "B" readers and certified radiologists, with the remaining physician, Dr. Felson, a certified radiologist.[23] I find this x-ray negative on the basis that the five (5) negative readings represent the preponderance of the medical opinion on this film.

The second x-ray in conflict is from April 11, 1985 and was read by five (5) physicians, who with the exception of Dr. Byers,[24] are all "B" readers and board certified radiologists. Of the five (5) interpretations, only Dr. Byers' was interpreted as positive (DX 22.31). Since the more qualified physicians found the film to be negative, I find this x-ray to be negative.

Another x-ray in conflict was performed on February 4, 1988 and interpreted by four (4) physicians. Three (3) of those physicians, Drs. Scott, Fino and Wheeler,[25] interpreted the x-ray as negative. Dr. Sargent, a "B" reader and certified pulmonologist, read the film as positive for pneumoconiosis.[26] As with the previous x-rays, I find this x-ray to be negative.

The interpretation of the June 13, 1990 is in conflict as well. Drs. Wiot, Spitz and Fino, all "B" readers, read the x-ray as negative. Of the three (3), Drs. Wiot and Spitz[27] are certified radiologists, whereas Fino is a certified pulmonologist. The sole positive interpretation was given by Dr. Mullens, a certified radiologist,[28] who commented that Claimant had mild pulmonary hyperinflation and ill-defined infiltrate, consistent with pneumoconiosis (DX 22.83.3). I find this x-ray negative on the basis that the three (3) negative readings of the four (4) represent the preponderance of the medical opinion of this film.

The next interpretation in conflict came from the August 4, 1992 x-ray. As with the June 13, 1990 x-ray, this film was interpreted as negative by three (3) physicians (Drs. Wiot, Spitz and Fino), as opposed to the one (1) positive reading done by Dr. Sargent. As with the previous x-rays, I find this reading to be negative.

The final conflicting x-ray interpretation is from June 28, 2000. Taken from this x-ray are two

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[23] The curriculum vitae of Drs. Halbert (DX 22-107, Poulos (DX 22-107), Felson (DX 22-107), Spitz (DX 22-84), Wheeler (DX 22-107) and Scott (DX 22-107) have been admitted into evidence.

[24] Dr. Byers is a "B" reader.

[25] Drs. Scott and Wheeler are "B" readers and certified radiologists, whereas Dr. Fino is a "B" reader and certified pulmonologist. Dr. Fino's curriculum vitae has been admitted into evidence at DX 22-82).

[26] Dr. Sargent's curriculum vitae has been admitted into evidence at DX 22-107.

[27] The curriculum vitae of Drs. Wiot and Spitz have been admitted into evidence at DX 22-84.

[28] The curriculum vitae of Dr. Mullens was admitted into evidence at DX 22-83.7.

(2) positive readings made by Drs. Patel and Barrett, as opposed to the three (3) negative readings made by Drs. Wheeler, Scott and Fino, all of whom are "B" readers and certified radiologists, with the exception of Dr. Fino who is a certified pulmonologist. It is alleged that Drs. Patel and Barrett are "B" readers and certified radiologists; however, neither physician has had his curriculum vitae admitted into evidence. As such, I give greater weight to the negative re-readings of Drs. Wheeler, Scott and Fino.

Having resolved the conflicting x-rays as negative, that leaves only two (2) positive x-rays[29] on record, as opposed to thirteen (13) negative readings. I give more weight to the thirteen (13) negative findings because there are multiple positive readings by physicians with special radiographical qualifications. In ***Adkins v. Director, Owcp,*** 958 F.2d 49, 52 (4th Cir. 1992), the court exhibited disfavor in "counting heads." I do not give any special weight to "numerosity," but I note that there is a disparity and I attribute significant weight to that fact.

Another factor in determining whether a finding of pneumoconiosis exists upon an x-ray evidence is the date of the x-ray. In weighing x-rays based upon the "later evidence" rule, it is the date of the study, and not the date of the interpretation, which is relevant. ***Wheatley v. Peabody Coal Co.,*** 6 B.L.R. 1-1214 (1984). It is proper to accord greater weight to the most recent x-ray study of record. ***Stanford v. Director, OWCP,*** 7 B.L.R. 1-541 (1984); ***Tokarcik v. Consolidation Coal Co.,*** 6 B.L.R. 1-166 (1983). However, even if the most recent x-ray is positive, the judge is not required to accord it greater weight. Rather, the length of time between the x-rays studies and the qualifications of the interpreting physicians are factors to be considered. ***McMath v. Director, OWCP,*** 12 B.L.R. 1-6 (1988); **Pruitt v. Director, OWCP,** 7 B.L.R. 1-544; ***Gleza v. Ohio Mining Co.,*** 2 B.L.R. 1-436 (1979).

Even some of the readings that indicate that no pneumoconiosis is found, I note that the reports show infiltrate, scarring and cavity/bullous formation is found in the Claimant's right upper lobe (EX 5, EX 7, EX 20EX 13 EX 13, EX 14, EX 15, EX 16, EX 17, EX 21, EX 22, EX 23).

Despite the overwhelming superiority in negative interpretations, the two (2) positive readings were derived from x-rays taken on June 7, 1974 (DX 22.74.2) and February 25, 1976 (DX 22.26), nearly thirty (30) years ago. Thus, the "later evidence" rule is applicable and greater weight can be given to the thirteen (13) negative x-rays taken after the two (2) positive x-rays.

Based on the foregoing, the Claimant has failed to establish the presence of pneumoconiosis through x-ray evidence.

b. Autopsy or Biopsy Evidence

As there is no autopsy or biopsy evidence in the record, Section 718.202(a)(2) is not applicable.

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[29] Dr. Navani, a "B" reader and certified radiologist read Claimant's June 7, 1974 and February 25, 1976 x-rays as positive. Moreover, Dr. Navani's curriculum vitae has been admitted into evidence at DX 22-107.

c. Presumptions

Under Section 718.202(a)(3), the existence of pneumoconiosis may be established through the application of the presumptions described in Sections 718.304, 718.305 or 718.306. Section 718.304 requires x-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. The rebuttable presumption of Section 718.305 is not available to the Claimant because he filed his application after January 1, 1982. And Section 718.306 is only applicable in the case of a deceased miner who died on or before March 1, 1978 and who was employed twenty-five (25) or more years prior to June 30, 1971.

d. Other Relevant Evidence

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative.[30] 20 C.F.R. § 718.202(a)(4); ***Compton v. Beth Energy Mines, Inc. and Director, OWCP,*** 98-B.L.A.-14 (1998).

The record contains eighteen (18) medical reports, ranging from chart notes to lengthy and detailed medical reports, submitted by eight (8) physicians. Four (4) of the physicians – Drs. Kanwal, Robinette, Bailey and Rasmussen – diagnosed Claimant as having coal workers' pneumoconiosis, whereas the remaining four (4) – Drs. Sargent, Fino, Branscomb and Hippensteel – did not.

On November 21, 1983, Dr. Kanwal examined the Claimant and administered a full range of laboratory studies (DX 22.17). Additionally, Dr. Kanwal reviewed Claimant's occupational, social and medical histories. After a review of each, Dr. Kanwal diagnosed Claimant as having coal workers' pneumoconiosis and chronic bronchitis, of which both relate to his prolonged coal dust exposure.

Dr. Robinette, Claimant's treating physician, also diagnosed the Claimant as having coal workers' pneumoconiosis with a moderately severe ventilatory defect (DX 22.44.2). Furthermore, Dr. Robinette opined that Claimant's pulmonary disease is irreversible (Id.).

Dr. Bailey had the opportunity to examine the Claimant on two (2) occasions (DX 22.62.4). After doing so, Dr. Bailey concluded that Claimant has an advanced pulmonary disease with evidence of severe emphysema and polycythemia (Id.). Dr. Bailey added, however, that Claimant's black lung is probably substantial, at a point in which Claimant should be considered for benefits (Id.).

Dr. Rasmussen was the final physician to conclude that Claimant has coal workers' pneumoconiosis (DX 6). Before doing so, Claimant performed a physical examination and laboratory tests on Claimant, as well as reviewing Claimant's chest x-rays and occupational and medical histories (Id.). In addition to CWP, Dr. Rasmussen diagnosed Claimant as having chronic obstructive pulmonary disease (COPD)/emphysema (Id.).

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[30] The Benefits Review Board has held that the clause in this section "notwithstanding a negative x-ray" must be read to mean "even if there is a negative x-ray." See ***Taylor v. Director, OWCP,*** 9-B.L.R. 1-22 BLA (1986). Thus, all physicians' reports must be considered, including those in which the physician's opinion is based in part upon a positive x-ray.

As noted above, four (4) physicians concluded that Claimant did not have coal workers' pneumoconiosis. Despite reading Claimant's x-rays as positive for CWP, Dr. Sargent ruled out coal workers' pneumoconiosis and instead diagnosed Claimant as having chronic bronchitis and probably COPD, neither related to Claimant's exposure to coal dust (DX 22.31, DX 22.48). In each of his medical reports, Dr. Sargent carefully reviewed Claimant's medical and occupational histories, as well as his x-rays and clinical studies (Id.). I discount Dr. Sargent's medical opinion based on his decision to rule out coal workers' pneumoconiosis even though he interpreted Claimant's x-rays as positive for CWP. A report may be given little weight where it is internally inconsistent and inadequately reasoned. ***Mabe v. Bishop Coal Co.,*** 9 B.L.R. 1-67 (1986).[31]

Following his review of his Claimant's x-rays, laboratory studies and medical history, Dr. Fino concluded that Claimant does not suffer from an occupational acquired pulmonary condition (DX 22.106). Additionally, Dr. Fino diagnosed Claimant with a moderate obstructive ventilatory defect secondary to smoking (Id.). In his January 3, 2000 medical report, which was based on a review of Claimant's CT-scan, Dr. Fino concluded that Claimant had no pleural or parenchymal abnormalities consistent with occupational pneumoconiosis.

Dr. Branscomb concluded that Claimant suffers from neither clinical, nor legal pneumoconiosis (DX 22.105). Before making his diagnosis, Dr. Branscomb reviewed Claimant's present and past medical histories, occupational history, chest x-rays, physical examinations, laboratory tests and physician depositions (Id.). However, Dr. Branscomb, like Dr. Fino, did not physically examine the Claimant before making his diagnosis (Id.).

Most recently, Dr. Hippensteel concluded that Claimant's pulmonary impairments are related to chronic bronchitis and not coal workers' pneumoconiosis (EX 1). In doing so, Dr. Hippensteel reviewed Claimant's lengthy medical record (physical exams, laboratory studies[32], other medical reports, physician depositions and chest x-rays) and his occupational, medical and social histories (Id.).

In evaluating medical opinions, I must first determine whether opinions are based on objective documentation and then consider whether the conclusions are reasonable in light of that documentation. A well-documented opinion is based on clinical findings, physical examinations, symptoms and a patient's work history. ***Fields v. Island Creek Coal Company,*** 10 B.L.R. 1-19 (1987); ***Hoffman v. B&G Construction Company,*** 8 B.L.R. 1-65 (1985). For a medical opinion to be "reasoned," the underlying documentation and data should be sufficient to support the doctor's conclusion. ***Fields,*** *supra*. With respect to the existence of pneumoconiosis, I find the preceding medical opinions, with the exception Dr. Sargent's, from the similarly qualified physicians to be well-documented.

Another factor to consider in evaluating conflicting medical reports is the recency of the report. ***Clark v. Karst-Robbins Coal Company,*** 12 B.L.R. 1-149 (1989)(*en banc*). A medical report

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[31] See also ***Cranor v. Peabody Coal Co.,*** 22 B.L.R. 1-1 (1999)(*en banc* on recon.)(the Board concluded that it was proper for the administrative law judge to give less weight to the report of Dr. Fino because his opinion was based upon a CT-scan which was not in the record and he did not have the benefit of reviewing the two most recent qualifying pulmonary function studies).

[32] EX 3.

containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. ***Gillespie v. Badger Coal Co.,*** 7 B.L.R. 1-839 (1985). see also ***Bates v. Director, OWCP,*** 7 B.L.R. 1-113 (1984)(more recent report of record entitled to more weight than reports dated eight years earlier); ***Kendrick v. Kentland-Elkhorn Coal Co.,*** 5 B.L.R. 1-730 (1983). Finally, a medical opinion may be given little weight if it is vague or equivocal. ***Griffith v. Director,*** OWCP, 49 F.3d 184 (6th Cir. 1995); ***Justice v. Island Creek Coal Company,*** 11 B.L.R. 1-91 (1988).

Based on the time frame that such opinions were rendered, I give less weight to the medical reports of Drs. Kanwal (DX 22-17), Bailey (DX 22.62.7), Robinette (DX 22.44.2, DX 47.1), Sargent (DX 22.31, DX 22.48, DX 22.94), Branscomb (DX 22.105) and Fino (DX 22.106). The dates of these reports range anywhere from seventeen (17) to seven (7) years before the date of Claimant's most recent application for benefits. While I am required to take into account evidence of the entire record, I find that these older medical reports are not as relevant as the medical reports submitted since Claimant's March 28, 2000 application for benefits.

While Dr. Fino concluded in his January 3, 2000 report that Claimant has no pleural or parenchymal abnormalities consistent with occupational pneumoconiosis, he did so after reviewing only a CT-scan without having reviewed any of Claimant's recent laboratory studies. He also did not examine the Claimant. It is for these reasons that I give little weight to Dr. Fino's January 3, 2000 medical report.

In weighing medical evidence, more weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. ***Onderko v. Directo, OWCP,*** 14 B.L.R. 1-2 (1989). Furthermore, the Fourth Circuit noted the importance of conducting multiple examinations over time in ***Adkins v. Director, OWCP,*** 958 F.2d 49 (4th Cir. 1992), stating that "a comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than the pioneer physician."

It appears from the record that Dr. Robinette, a "B" reader and certified pulmonologist, is Claimant's treating physician for his lungs (EX 6). According to Dr. Robinette, he has been treating Claimant regularly since 1985 (DX 22-53). And following each of his earlier examinations of Claimant, Dr. Robinette diagnosed Claimant as having coal workers' pneumoconiosis. However, Dr. Robinette's June 12, 2000 medical report (DX 21.2) is silent on the issue of pneumoconiosis. Thus, Dr. Robinette's medical report has no probative value as to the issue of pneumoconiosis. Therefore, despite being Claimant's treating physician, I give little weight to Dr. Robinette's June 12, 2000 report.

Despite submitting a well-documented report (EX 1), I discount Dr. Hippensteel's medical opinion due internal conflicting statements, inconsistencies between positions taken in the report and testimony given in a deposition, and confusion surrounding Dr. Hippensteel's understanding of the legal definition of pneumoconiosis in coming to his conclusion that Claimant does not suffer from coal workers' pneumoconiosis. Clinical pneumoconiosis refers to the lung disease caused by fibrotic reaction of the lung tissue to inhaled dust, which is generally visible on chest x-rays as opacities. ***Usery v. Turner-Elkhorn Mining Co.,*** 428 U.S. 1, 7, 96 S.Ct. 2882, 2888-89, 49 L.Ed.2d 752 (1976). Legal pneumoconiosis, on the other hand, refers to all lung diseases which meet the statutory or

regulatory definition of being any lung disease which is significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201; ***Hobbs v. Clinchfield Coal Co.,*** 917 F.2d 790, 792 (4th Cir. 1990).

The Act provides benefits for any chronic lung disease significantly related to, or substantially aggravated by, dust exposure in coal mine employment. Moreover, contrary to strict clinical usage, the Act defines any such pulmonary disease as "pneumoconiosis". In evaluating the opinions of physicians, ALJs and the BRB must bear in mind that medical professionals generally use medical terms of art, not legal ones. ***Compton v. Beth Energy Mines, Inc.,*** 1998-B.L.A.-14 (1998)(citing ***Roberts v. West Virginia C.W.P. Fund,*** 20 B.L.R. 2-69 (4th Cir. 1996). To physicians, 'pneumoconiosis' is a single disease, arising in whole from a specific cause (dust exposure), and producing a characteristic form of pulmonary damage. ***Id.*** To the law, 'pneumoconiosis' is an array of diseases, arising in whole or in part from dust exposure, and the form of pulmonary damage is irrelevant, so long as some impairment arises from it. ***Id.***

Not only did Dr. Hippensteel acknowledge that the definition of coal workers' pneumoconiosis does include chronic obstructive pulmonary disease[33], but he also diagnosed Claimant as having a disabling chronic obstructive pulmonary disease consistent with his history of smoking (DX 27). Dr. Hippensteel further testified in his deposition that the definition of coal workers' pneumoconiosis is not always associated with restrictive lung disease (EX 27.15-16, 33-34). Essentially, Dr. Hippensteel is under the impression that a miner must present a restrictive lung disease in order to have coal workers' pneumoconiosis. He emphasized that he did not find pulmonary fibrosis, which is representative of a restrictive impairment (Id. 35). He testified that he disputes Dr. Rasmussen's finding that the the values of the pulmonary function studies had improved from the Dr. Rasmussen's testing. However, on cross examination, he admitted that given all his reservations concerning the etiology and enumeration of the factors, the evidence is competent to produce pneumoconiosis (Id. 32-36).

On one hand, Dr. Hippensteel disputes Dr. Rasmussen's opinion, advising that he had failed to rule out fungus and smoking, while on the other hand, Dr. Hippensteel determined that the Claimant is totally disabled, but as a result of either a fungal disorder or smoking, asthma, or all of them (Id. 23-26). He noted an elevated carboxyhemoglobin finding[34], but also went into depth about his diffusing capacity evaluation, diagnosing emphysema (Id). He testified that he would expect to find fibrosis with it if it were pneumoconiosis (Id. 16). Again, on the other hand, he says that the claimant has emphysema, characterized as asthma (Id. 14, 32).[35] These are given as reasons why pneumoconiosis

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[33] Chronic obstructive lung disease . . . is encompassed within the definition of pneumoconiosis for purposes of entitlement to Black Lung Benefits. ***Warth v. Southern Ohio Coal Co.,*** 60 F.3d 173 (4th Cir. 1995).

[34] Id. 11-18 .

[35] Note that Dr. Hippensteel relied on diffusion studies, which are not enumerated as pulmonary function studies by 20 CFR § 718.103. They are generally to be evaluated as "other medical tests

is not present. However, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. ***Robinson v. Director, OWCP***, 3 B.L.R. 1-798.7 (1981); ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983). Therefore, in reading the report and the deposition testimony, especially the responses to cross examination, Dr. Hippensteel considered both a restrictive disorder and chronic obstructive pulmonary disease are present.

In reality, the only dispute is as to whether there is pneumoconiosis and as to causation. I do not accept the opinions he rendered are as reasoned as Dr. Rasmussen's because they are confusing, are internally inconsistent and are contrary to logic. Dr. Hippensteel advised that granulomatous disease can be caused by fungal infections, and that they look like pneumoconiosis (Id, 28). Moreover, he had to admit that coal dust exposure had an impact simply because a claimant may also have had a fungal infection by history (Id. 34). He testified that there is reversibility shown, and improvement, but does not deny that several causes may be present in the same claimant and in this record.

The Board has held that the administrative law judge may discount the opinion of a physician whose medical assumptions are contrary to, or in conflict with, the spirit and purposes of the Act. ***Wetherill v. Green Construction Co.,*** 5 B.L.R. 1-248, 1-252 (1982). Chronic obstructive pulmonary disease, as well as an array of other diseases, are included in the definition of legal pneumoconiosis for purposes of entitlement to Black Lung benefits. ***Warth v. Southern Ohio Coal Co.,*** 60 F.3d 173 (4th Cir. 1995). The Fourth Circuit in ***Warth*** added that the assumption by a physician that pneumoconiosis causes a restrictive impairment, rather than an obstructive impairment, is erroneous and undermines his conclusions. ***Id.*** It is obvious that Dr. Hippensteel muddled the legal definition of pneumoconiosis upon making his diagnosis. It is possible that a claimant may have both a restrictive and an obstructive disorder. Emphysema is a restrictive disease and is associated with the legal definition of pneumoconiosis. Based on his remarks in his deposition, Dr. Hippensteel is under the impression that a miner must present a restrictive lung disease in order to have coal workers' pneumoconiosis. He also assumed that the presence of fungus and tobacco smoking and pneumoconiosis are mutually exclusive diagnoses. He did discuss the nature of the findings on X-ray and that he did not find pneumoconiosis on reading the X-ray he took despite noting that there were positive findings. I note that some of the findings in this fact pattern are similar to those discussed in ***Stiltner v. Island Creek Coal Co***, 86 F.3d 337 (4th Cir. 1996), *reh'g. denied*, 86 F.3d 337 (4th Cir. 1996) (a physician's opinion should not be discredited merely because he states that coal dust exposure would "likely" cause a restrictive, as opposed to obstructive, impairment). But Dr.

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u9nder 20 CFR § 718.107. The results of any medically acceptable test or procedure reported by a physician not addressed in this subpart which test or procedure tends to demonstrate the presence or absence of pneumoconiosis or the sequelae of pneumoconiosis or the presence or absence of a respiratory or pulmonary impairment, may be submitted in connection with a claim and shall be given appropriate consideration. However, the record does not include a basis for evaluating these tests. No learned journal or other authoritative materials were proffered to substantiate the conclusions given.

Hippensteel's opinions go beyond a reasonable degree of probability (let alone certainty) and even he has to admit it is possible that all of his opinions are incorrect.

I note that there is nom X-ray evidence of pneumoconiosis. However, even some of the readings that indicate that no pneumoconiosis is found, I note that the reports show infiltrate, scarring and cavity/bullous formation is found in the Claimant's right upper lobe (EX 5, EX 7, EX 20EX 13 EX 13, EX 14, EX 15, EX 16, EX 17, EX 21, EX 22, EX 23). Thesae are all rastionalized that they stem from a cause other than pneumoconiosis. However, none of these except Dr. Hippensteel considered all of the other factors involved.

Taking Dr. Hippensteel's statements in connection with the Fourth Circuit's interpretation of legal pneumoconiosis, it can be deduced that Dr. Hippensteel's diagnosis is undermined by false assumptions. Although I accept Dr. Hippensteel's opinion that the Claimant is totally disabled by a respiratory impairment, I discount the conclusion that pneumoconiosis is contraindicated.

As mentioned above, Dr. Rasmussen's June 28, 2000 medical report, on the issue of pneumoconiosis, is a well-documented and reasoned opinion. Dr. Rasmussen based his report on his physically examination and laboratory tests of Claimant, as well his review of one of Claimant's more recent chest x-rays (DX 6). Dr. Rasmussen considered the Claimant's history when he made his opinion. His opinion reflects the Claimant's medical history and is consistent testing results obtained by Dr. Hippensteel. Dr. Rasmussen is a B Reader and is certified in Internal Medicine. I note that Dr. Rasmussen's opinion is substantiated by the diagnosis of Dr. Robinette, the treating physician (DX 22-41). For all of the above reasons, after a review of the complete record, I assign greater weight to the medical report of Dr. Rasmussen. Based on this, I find that Claimant has established the existence of pneumoconiosis by a preponderance of the evidence.

2. Etiology of Pneumoconiosis

In order to find a Claimant eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. 20 C.F.R. §718.203(a). Where a miner is credited with ten (10) or more years of coal mine employment and is suffering from pneumoconiosis, it will be presumed, in the absence of contrary evidence to the contrary, that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten (10) years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the parties have stipulated that the Claimant had nineteen (19) years of coal mine employment, he receives the presumption that his pneumoconiosis arose out of coal mine employment. And since the record does not contain contrary evidence that shows the Claimant's pneumoconiosis arose out of alternative causes, I find that Claimant's pneumoconiosis arose from his coal mine employment.

Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Section

718.204(b)(2) provides the following methods for establishing total disability: (1) qualifying pulmonary functions tests; (2) qualifying arterial blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony.[36] Additionally, pneumoconiosis must be a "contributing cause" to the miner's total disability. ***Hobbs v. Clinchfield Coal Co.,*** 917 F.2d 790, 792 (4th Cir. 1990). Therefore, a claimant must first establish that he is totally disabled and second, that his pneumoconiosis is a contributing cause to his disability.

1. Total Disability

Having already demonstrated that Claimant is totally disabled from a respiratory perspective, I am left to determine whether his disability is caused by his pneumoconiosis.

2. Causation

Although the weight of the evidence sufficiently demonstrates that Claimant is totally disabled, he must still establish by a preponderance of the evidence that his disability is caused by his coal workers' pneumoconiosis. That is, the claimant must prove that his pneumoconiosis is a "substantially contributing cause" to his totally respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c)(1); ***Milburn Colliery Co. v. Hicks,*** 138 F.3d 524, 529 (4th Cir. 1998). To be a contributing cause, the claimant's coal mining must be a necessary condition of his disability. If the claimant would have been disabled to the same extent and by the same time in his life if he had never been a miner, then claimant has failed to meet his burden. On the other hand, if his mining has contributed to his disability, then the burden is met. ***Robinson v. Pickands Mather & Co.,*** 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990). Usually, such a connection is demonstrated by medical opinion. In evaluating such evidence, an administrative law judge may not substitute his or her medical opinion for that of a physician. ***Fuller v. Gibraltar Coal Co.,*** 6 B.L.R. 1-1291 (1984).

Since there is no evidence of complicated pneumoconiosis and Claimant has filed his present claim after 1982, he is not able to rely on any of the regulatory presumptions. Instead, medical opinion in the record will determine whether Claimant's total respiratory disability is due to pneumoconiosis.

As was the case with the issue of existence of pneumoconiosis, the same physicians that diagnosed Claimant as having coal workers' pneumoconiosis also concluded that his CWP is due to his exposure to coal mine dust.[37] Conversely, the doctors, who concluded that Claimant does not have coal workers' pneumoconiosis, also concluded that his pulmonary impairments are not due to his exposure to coal mine dust.[38] As I did with the pneumoconiosis issue, I must weigh the medical reports

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[36] The Board has held that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. ***Tedesco v. Director, OWCP,*** 18 B.L.R. 1-103 (1994).

[37] See the medical reports of Drs. Kanwal (DX 22.17), Robinette (DX 22.44.2), Bailey (DX 22.62.4) and Rasmussen (DX 6).

[38] See the medical reports of Drs. Sargent (DX 22.31, DX 22.48, DX 22.94), Fino (DX 22.106, EX 18), Branscomb (DX 22.105) and Hippensteel (EX 1).

of the various physicians. In doing so, I must again take into account the objectivity and reasonableness of the report, as well as the recency of the report in relation to the date of Claimant's current application for benefits.

As I did above, I give little weight to Dr. Kanwal's opinion, as it was rendered some eighteen (18) years ago. Dr. Bailey's medical report is also given less weight, not only because of the lapse of time between his examination of Claimant and the date of Claimant's most recent application for benefits (ten years), but also because I find his opinion to be 'equivocal' and/or 'vague.'[39] In his November 7, 1990 medical report, Dr. Bailey concluded that Claimant's black lung is probably substantial and believes that Claimant should be considered for black lung benefits (DX 22.62.4). It is for these reasons that I give little weight to the medical report of Dr. Bailey.

I again assign less weight to the medical reports of Dr. Robinette, despite his status as Claimant's treating physician. Dr. Robinette's earlier reports, dated August 15, 1987 (DX 22.44.2) and February 5, 1988 (DX 22.47.1), are again discounted due to the lapse of time between the reports and the time of Claimant's recent application for benefits. Furthermore, Dr. Robinette's medical report from June 12, 2000 (DX 21.2) is also discounted because his report is silent as to the issue of causation (Id.). Therefore, I give little weight to the medical opinion of Dr. Robinette.

I give less weight to the medical reports of Drs. Sargent (DX 22.31, DX 22.36, DX 22.48, DX 22.48, DX 22.94) and Branscomb (DX 22.105) for the same reasons as I did with the reports of Drs. Kanwal and Bailey. The most recent medical report submitted by Dr. Sargent was from his August 4, 1992 physical examination of Claimant (DX 22.94), whereas Dr. Branscomb's only report was submitted on April 13, 1993 (DX 22.105). Because each of these reports were made approximately seven (7) to eight (8) prior to Claimant's current application for benefits, I do not find them to be relevant in determining whether Claimant's total disability was caused by his exposure to coal dust. Therefore, I give little weight to the medical opinions of Drs. Sargent and Branscomb.

Dr. Fino submitted medical reports on two (2) occasions, April 12, 1993 (DX 22.106) and January 3, 2000 (EX 18). As I alluded to earlier, a more recent report of record is entitled to more weight than reports dated eight (8) years earlier. ***Kendrick v. Kentland-Elkhorn Coal Co.,*** 5 B.L.R. 1-730 (1983). Because this is the case with Dr. Fino's earliest medical report, I give less weight to his April 12, 1993 report.

Alternatively, Dr. Fino's second report is based only upon his review of Claimant's January 3, 2000 CT-scan (EX 18) which failed to take into account the examinations of record, especially Claimant's pulmonary function tests which produced positive results (Id.). Where an Administrative

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[39] An opinion may be given little weight if it is equivocal or vague. ***Island Creek Coal Co. v. Holdman,*** 202 F.3d 873 (6th Cir. 2000)(a physician, who concluded that simple pneumoconiosis "probably" would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by 20 C.F.R. § 727.203(b)(3); ***Griffith v. Director, OWCP,*** 49 F.3d 184 (6th Cir. 1995)(treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); ***Justice v. Island Creek Coal Co.,*** 11 B.L.R. 1-91 (1988)(an equivocal opinion regarding etiology may be given less weight).

Law Judge determines that a miner suffers from pneumoconiosis, a medical opinion finding the miner does not suffer from the disease can carry little weight in assessing the etiology of the miner's total disability. ***Toler v. Eastern Associated Coal Co.,*** 43 F.3d 109, 116 (4th Cir. 1995). Therefore, Dr. Fino's medical opinion is inconsistent with the full weight of all the evidence on record. It is for these reasons that I discount the January 3, 2000 medical report of Dr. Fino.

In his June 28, 2000 medical report, Dr. Rasmussen indicated that Claimant has two (2) risk factors for his disabling lung disease: his history of cigarette smoking and his exposure to coal dust (DX 6). Dr. Rasmussen then concluded that Claimant's coal dust exposure is the principal risk factor behind Claimant's lung impairment (Id.). Dr. Rasmussen's opinion is a well-documented one insofar as he relied on Claimant's medical history, a physical examination and a pulmonary function test. 20 C.F.R. § 718.292(a)(4). Although Dr. Rasmussen did not offer much of an explanation for his conclusion that Claimant's disease was partially caused by his exposure to coal dust, the totality of his report indicates that he reached a "reasoned medical opinion." ***Island Creek Coal Co. v. Compton,*** 211 F.3d 203 (4th Cir. 2000); see ***Poole v. Freeman United Coal Mining Co.,*** 897 F.2d 888, 893-94 (7th Cir. 1990). There are several factors that an administrative law judge must consider in determining the weight to accord a particular opinion, and the detail of the analysis in the opinion is just one (1) of them. ***Underwood v. Elkay Mining, Inc.,*** 105 F.3d 946, 949 (4th Cir. 1997). Based on this, I accord greater weight to the medical report of Dr. Rasmussen.

In his March 12, 2001 medical report, Dr. Hippensteel concluded that Claimant's significant pulmonary impairment is related to his severe fungal infection and smoking history, rather than his coal dust exposure (EX 1). He notes that laboratory studies show that the Claimant has severe airflow obstruction with minimal improvement post-bronchodilator. From this he extrapolates that the cause is fungus and/or chronic obstructive pulmonary disease.[40] In testimony, he also attributed emphysema to these findings and to arterial blood gas studies. I discount Dr. Hippensteel's medical opinion as to the issue of causation. Dr. Hippensteel is the only physician to give significance to Claimant's fungal infection as a reason for Claimant's pulmonary impairment (Id.). He had to admit on cross examination that it is not mutually exclusive to pneumoconiosis (EX 27). Furthermore, Dr. Hippensteel offers no medical findings to justify such causal relationship. He could not rule out pneumoconiosis as a contributing factor. In ***Jewell Smokeless Coal Corp. v. Street,*** 42 F.3d 241 (4th Cir. 1994), the Fourth Circuit concluded that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." Rather, "the miner must demonstrate that he has a totally disabling respiratory or pulmonary condition ... and show that his pneumoconiosis is a contributing cause to this total disability." ***Id.***

Even though Claimant has suffered from various ailments, fungal exposure, a stroke, and has an extensive history of smoking, it is insufficient to rule out pneumoconiosis as a contributing factor to his total disability. Moreover, Dr. Hippensteel fails to set forth any legitimate reasons for ruling out coal dust exposure as a cause or aggravation of that disease. It is for these reasons why I discount Dr. Hippensteel's medical opinion as to the issue of causation.

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[40] Because it is reversible.

Upon review of the medical opinion evidence, I give more credit Dr. Rasmussen's opinion based on my finding it to be better reasoned because of the thorough review of the contributing factors to Claimant's respiratory impairment. Furthermore, Dr. Rasmussen's findings are consistent to those made by Claimant's treating physician, Dr. Robinette. Conversely, I give less weight to the medical opinion of Dr. Hippensteel. Dr. Hippensteel could not rule out pneumoconiosis as a contributing factor, nor could he offer any legitimate reasons for ruling out coal dust exposure in coal mine employment as a cause or aggravation of that disease. In his report, he determined Claimant has functional disturbances that occurred during times of continued, heavy smoking. In his deposition, he determined that fungus caused infiltrate, scarring and cavity/bullous formation in his right upper lobe as a result of a prior fungal infection which were seen on an X-ray he has taken. These are apparent inconsistencies, but even if he is partly correct, pneumoconiosis is not ruled out as a cause of the Claimant's respiratory problems. As such, Dr. Rasmussen's medical opinion is more rational than Dr. Hippensteel's because it is less confusing and conflicted.

The Fourth Circuit Court of Appeals requires that pneumoconiosis be "a" 'contributing cause' to the claimant's total disability. ***Toler v. Eastern Associated Co.,*** *supra*; ***Jewel Smokeless Coal Corp. v. Street,*** 42 F.3d 241, 243 (4th Cir. 1994). Therefore, to qualify for benefits, the claimant need not prove that pneumoconiosis is the 'sole' or 'direct' cause of his respiratory disability, but rather that it has contributed to his disability. ***Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP,****supra* at 2-76. There is evidence on record that Claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, Dr. Rasmussen examined the Claimant and found him totally disabled due to a combination of cigarette smoking and coal mine dust exposure (DX 6). Dr. Rasmussen explained that, while both smoking and CWP could cause Claimant's impairment, CWP is the principal risk factor to Claimant's disability (Id.). This is more rational and logical than the rationale expressed by Dr. Hippensteel, which is confusing and conflicted. Based on the factors above, Dr. Rasmussen's opinion is entitled to significant weight.

By offering Dr. Rasmussen's medical opinion whereby Claimant's coal mine dust exposure is the principal risk factor in his disability, the Claimant has met his burden of establishing that his pneumoconiosis is a "substantially contributing cause" to his totally respiratory or pulmonary impairment. Having already discounted Dr. Hippensteel's medical opinion and rejected the medical opinions of the other physicians, who concluded that the Claimant does not have pneumoconiosis, and therefore Claimant's total disability is not related to dust exposure in coal mine employment, I find it more likely than not that Claimant's disability, whether coal workers' pneumoconiosis or chronic obstructive pulmonary disease, is significantly related to his coal mine dust exposure.

In support, the Fourth Circuit has held that the form of pulmonary damage is irrelevant so long as some impairment arises from it and that the claimant must prove that pneumoconiosis contributed to the total disability. ***Roberts v. West Virginia C.W.P. Fund,*** 20 B.L.R. 2-69 (4th Cir. 1996); ***Toler v. Eastern Associated Coal Co.,*** 43 F.3d 109, 116 (4th Cir. 1995). Furthermore, the Fourth Circuit appears to make no distinction concerning the degree of contribution; nor does the Benefits Review Board. ***Compton v. Beth Energy Mines, Inc.,*** 1998-B.L.A.-14 (1998). Thus, on this basis alone, I could find this element of entitlement established.

Therefore, after a review of the complete record, I accept that the Claimant has chronic

obstructive pulmonary disease, and even if I accept that he also has emphysema and has been a smoker, I accept that pneumoconiosis was caused by to his coal mine dust exposure. Paraphrasing the Court's language in ***Robinson,*** *supra*, I find Claimant would not have been disabled to the same degree and by the same time in his life if he had never been a coal miner. I find the Claimant has met his burden of proof in establishing the existence of total disability due to legal coal miners' pneumoconiosis. ***Director, OWCP v. Greenwich Collieries,*** 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994). I find that Mr. Woods became totally disabled due to pneumoconiosis on June 1, 2000. 33 U.S.C. §§ 906(a).

Conclusion

Due to the lapse of time between the submission of a majority of the medical reports and the date Claimant filed his most recent duplicate claim, I essentially was left to weigh the physician evidence of only a few doctors. As noted previously, I discounted Dr. Fino's medical opinion because he is not an examining physician and due to his failure to review Claimant's positive pulmonary functions tests and gave less weight to the medical opinion of Dr. Robinette for his failure to address the issues of pneumoconiosis and causation. Thus, I was left to mainly weigh the medical opinion evidence of Drs. Rasmussen and Hippensteel.

I found the medical opinions of Drs. Rasmussen and Hippensteel to be somewhat similar, with the main point of contention surrounding the existence of pneumoconiosis and the issue of causation. Drs. Rasmussen and Hippensteel agree on the issue of total disability, as supported by their positive pulmonary function tests of Claimant. However, in weighing the medical evidence as to the issues of pneumoconiosis and causation, I give greater weight to the medical opinion of Dr. Rasmussen for two (3) reasons: opinions that are internally conflicted and inconsistent between the written report and deposition testimony; Dr. Hippensteel's failure to look at other possible contributing factors to Claimant's total respiratory disability failure to look at other possible contributing factors to Claimant's total respiratory disability, and confusing statements as to the nature of legal pneumoconiosis.

Claimant, having demonstrated a material change in conditions, has established the presence of pneumoconiosis that arose out of coal mine employment and that his total respiratory impairment is due to pneumoconiosis. Having established all the necessary elements, Scott A. Woods is entitled to benefits under the Act, augmented for one (1) dependent.

ORDER

IT IS ORDERED that the claim for benefits filed by Scott A. Woods is **granted.** The Employer, **Clinchfield Coal Company,** shall:

1. Pay to the Claimant, all benefits to which he is entitled, including augmented benefits to his dependent wife, Ruth Phillips Woods, and daughter, Kimberly Woods, under the Black Lung Benefits Act, commencing as of June 1, 2000, the month in which the Miner became entitled (33 U.S.C. §§ 906(a));
2. Pay to the Secretary of Labor reimbursement for any payment the Secretary has made to Scott A. Woods under the Act, and to deduct such amounts, as appropriate, from the amount

the Employer is ordered to pay under paragraph 1 above;

3. Pay to the Secretary of Labor interest as provided by law under Section 6621 of the Internal Revenue Code of 1954. Interest is to accrue thirty (30) days from the date of the initial determination of entitlement to benefits. 20 C.F.R. §§ 725.608.

4. Claimant's attorney is granted thirty (30) days to submit an application for fees conforming to the requirements of 20 C.F.R. §§ 725.365 and §§ 725.366.

SO ORDERED.

A
Daniel F. Solomon
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.